STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
ADDING MEMBERS TO AN EXISTING GROUP PROVIDER APPLICATION FORM

Group Name:		**Group Email Address:**	
Service Location Address:		**Group National Provider Identifier (NPI) Number:**	
		Group Taxonomy (ies):	
Pay To Address:		**Group Tax Identification Number:**	
Mail To Address:		**School Dept. Tax Identification Number:**	
Phone Number:		**HP Use Only**	
Fax Number:		**Census Track:**	**County Code:**
Group Email address:		**Town Code:**	**Location Code:**

NEW GROUP MEMBERS:

I understand fully the standard of participation as stated in the State of Rhode Island, Executive Office of Health and Human Services, Provider Agreement Form (enclosed in enrollment packet) and will participate in the Rhode Island Medicaid Program in accordance with these standards.

PROVIDER NAME	EFFECTIVE DATE w/GROUP	NATIONAL PROVIDER IDENTIFIER	TAXONOMY(S)	LICENSE #	PROVIDER TYPE & SPECIALTY	SIGNATURE	DATE

Signature of Provider, Senior Partner, or Chief Corporate Officer of Group **Title**

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE, NPI LETTER WITH TAXONOMY FOR EACH GROUP MEMBER LISTED*****
PLEASE LIST ADDITIONAL GROUP PROVIDERS ON NEXT PAGE

PLEASE LIST ADDITIONAL MEMBERS JOINING GROUP:

PROVIDER NAME	EFFECTIVE DATE w/ GROUP	NATIONAL PROVIDER IDENTIFIER	TAXONOMY(S)	LICENSE #	PROVIDER TYPE & SPECIALTY	SIGNATURE	DATE

<u>*PLEASE FURNISH A COPY OF THE CURRENT LICENSE, NPI LETTER WITH TAXONOMY FOR EACH GROUP MEMBER LISTED***</u>**